AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____ _____

Patient Name Date of Birth Social Security Number

_____ _____

Complete Address Telephone Number

Telephone number of the organization or individual:_____

The information may be disclosed to and used by the following individual or organization: (going to)

TAMASSEE DAR SCHOOL, P.O. BOX, 8, TAMASSEE, SC 29686

Telephone number of the organization or individual: **864-944-3022 FAX: 864-944-2004**

Purpose of Request:____Residential Placement_____

The following information is to be disclosed:

____ Physicians notes
_____ Lab Results
_____ X-ray reports
_____ Mental Health information
__X__ **Complete medical record including records contained within from other sources**

____ **Initials**: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

____ **Initials:** I understand that any disclosure of information carries the potential for re-disclosure and that the information then may be protected by federal confidentiality rules.

____ **Initials:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that revocation will not apply to information already released based on this authorization.

____ **Initials**: I understand that authorizing the disclosure of health information is voluntary.

____ **Initials:** I understand that I may inspect or obtain a copy of the information used or disclosed.

_____ _____

Signature of Patient or Legal Representative Date of Release

_____ _____

If not patient, relationship of legal representative to patient Date release will expire (not to exceed 6 months)

ALL INFORMATION MUST BE COMPLETE TO RELEASE MEDICAL RECORDS